*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

Dear Applicant:

Pursuant to your request, enclosed is the material necessary to apply for a New Jersey license to practice respiratory care. Please review this material carefully. Some portions of this package apply to credentialed practitioners who qualify for permanent licensure. Other portions apply to graduates of an accredited Respiratory Care Program who have not yet passed the N.B.R.C. entry-level examination, but who qualify for a temporary license in New Jersey.

**Vital Step in Application Process:**

**You must remember to call the Board's staff at (973) 504-6485 to be certain that the Board has in fact received both your application for licensure and the application fee BEFORE you request either your transcripts from any school you have attended or any documentation from any other parties. (For example, all medical verification forms.) In addition, please note that 1) under the medical conditions section of the application (question number 7), there are instances when the answer "not applicable" may apply, and 2) it is a very good idea to make sure that you have read the entire application before filling it out.**

## All applicants for licensure must show evidence of:

1. Having earned a U.S. high school diploma or its equivalent;
2. Having successfully completed:
   a. A Respiratory Care Program accredited by the Joint Review Committee for Respiratory Care Education (J.R.C.R.C.E.) of the Council on Allied Health Education and Accreditation, or its successor; and
   b. The entry-level examination of the National Board of Respiratory Care (N.B.R.C.).

It is the responsibility of individual candidates for licensure to make arrangements to sit for the N.B.R.C. examination or, if applicable, to verify existing credentials. Candidates for temporary licensure are expected to sit for the next available exam. In order to expedite the processing of your application and to avoid further expense, temporary license candidates should complete the Examination Score Release form and return it to the N.B.R.C. Inquiries about the exam or the verification of credentials should be directed to:

**The National Board for Respiratory Care, Inc.**
18000 W. 105th Street
Olathe, KS 66061-7543
Tel. (913) 895-4900
www.nbrc.org

Specific instructions will follow. Please be sure to follow each instruction with extreme care. Different data may be required to answer each question, and an incomplete application cannot be processed. You should direct any questions you may have to the Board's office at the address indicated above.

Very truly yours,
State Board of Respiratory Care

Dorcas K. O'Neal
Executive Director

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Respiratory Care Checklist
## Requirements for Permanent Licensure in New Jersey

**Below is a numbered list of the documents required for licensure. Failure to submit these documents will delay processing. Please read this list carefully. Put a check in each of the boxes on this list as you complete each applicable requirement.**

1. ☐ **Notarized Application**

   The **notarized** application is to be submitted with a **2" by 2" passport-size photograph** and a **nonrefundable fee of $125.00** in the form of a **certified check, personal check or money order**, payable to the New Jersey State Board of Respiratory Care. **Please note that a post office box may only be used as your address of record if you also provide another address that includes a street, city, state and ZIP code**. The application must be completed in its entirety and no line should be left blank.

2. ☐ **Biennial License Fee**

   **All permanent respiratory care licenses must be renewed biennially. Applicants are required to remit payment of $160.00** in the form of a **certified check, personal check, or money order**, payable to the New Jersey Board of Respiratory Care with the application fee. This fee may be prorated for the second year of the biennial licensure period. On March 31st of every **odd** year, the biennial licensure fee is $80.00 until the biennial expiration date March 31st of the following **even** year.

3. ☐ **Certification of Valid Licensure**

   If applicable, this form is to be forwarded to each state or jurisdiction in which you are licensed. This form may be copied if you are licensed in more than one state or jurisdiction. **Each state or jurisdiction may have a fee for this service. It is the applicant's responsibility to contact each board to find out how much the fee is and where to send it.**

4. ☐ **Certificate of Good Standing Non-Respiratory Care Practitioner License/Registration/Permit/Certificate**

   All applicants are required to forward one form to each state where you hold or have held a state-issued license, registration, permit or certificate as a health care provider **other than** a respiratory care practioner. Extra copies may be photocopied if needed.

5. ☐ **New Jersey Employer's Statement Form**

   A. If you **have not worked** as a respiratory therapist in the State of New Jersey since the inception of the Board **(May 1992)**, please complete **Section I and sign the form** as instructed.

   B. If you are **currently employed** or have in the past worked in the State of New Jersey, please have your employer **complete Section II, answering all of the questions that are applicable**. This form should be photocopied if you have or have had more than one employer. You may also download the form at www.NJConsumerAffairs.gov.

6. ☐ **New Jersey Verification of Medical Employment**

   If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

7. ☐ **Out-of-State Verification of Medical Employment**

If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

8. ☐ **Verification of Non-Medical Employment**

If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

9. ☐ **N.B.R.C. Examination Score Release Form**

This form is to be completed and **sent to the N.B.R.C. (highlighted address on form)** with the appropriate fee for verification of your credentials which must be sent **directly** to the Board.

10. ☐ **Copy of High School Transcript with School Seal/Notarized High School Diploma**

All applicants are required to request that their official high school transcript or its equivalent be forwarded from the high school to this office. **Foreign graduates are required to have their transcripts evaluated by a Board-approved evaluator (the list of evaluators is attached). If your transcripts are not mailed directly from your high school, they must be notarized before sending them to the State Board of Respiratory Care.**

11. ☐ **Notarized Copy of Name Change**

If applicable, an applicant whose name has changed must forward a **notarized** copy of the documented proof of a name change to the State Board of Respiratory Care.

12. ☐ **Notarized Copy of Citizenship/Alien Registration Card**

If applicable, this **notarized** certificate must be provided to prove that you are a legal resident of the United States.

13. ☐ **Notarized Copy of the Certificate of Completion (Certificate/Degree)**

All applicants are required to submit a **notarized** copy of the Certificate of Completion **(certificate or degree from an accredited institution or college)** to the Board, proving successful completion of a Respiratory Care program accredited by the Committee on Accreditation for Respiratory Care.

14. ☐ **Certificate and Authorization Form for a Criminal History Background Check**

All applicants are required to submit a **Certification and Authorization Form for a Criminal History Background Check**. Please complete the form in its entirety, **sign the form** and return it to the mailing address on the previous page. If you live out-of-state, fingerprint cards **(if applicable)** with a complete set of instructions will be sent to you upon receipt of the Certification and Authorization Form for a Criminal History Background Check.

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Respiratory Care Checklist
## Requirements for Temporary Licensure in New Jersey

**Below is a numbered list of documents required for licensure. Failure to submit these documents will delay processing. Please read this list carefully. Put a check in each of the boxes on this list as you complete each applicable requirement.**

1. ☐ **Notarized Application**

   The **notarized** application is to be submitted with a **2" by 2" passport-size photograph** and a **nonrefundable fee of $125.00** in the form of a **certified check, personal check or money order**, payable to the New Jersey State Board of Respiratory Care. **Please note that a post office box may only be used as your address of record if you also provide another address that includes a street, city, state and ZIP code**. The application must be completed in its entirety and no line should be left blank.

2. ☐ **Temporary License Fee**

   Applicants are required to remit with the **notarized** application a **payment of $40.00** in the form of a **certified check, personal check or money order**, payable to the New Jersey Board of Respiratory Care.

3. ☐ **New Jersey Employer's Statement Form**

   A. If you **have not worked** as a respiratory therapist in the State of New Jersey since the inception of the Board **(May 1992)**, please **complete Section I and sign the form** as instructed.

   B. If you **are currently employed**/or have worked in the State of New Jersey, please **have your employer complete Section II, answering all of the questions that are applicable**. This form should be photocopied if you have or have had more than one employer. You may also download the form at www.NJConsumerAffairs.gov.

4. ☐ **New Jersey Verification of Medical Employment**

   If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. Please have it returned directly to this office at the above address by your employer(s). A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

5. ☐ **Out-of-State Verification of Medical Employment**

   If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. Please have it returned directly to this office at the above address by your employer(s). A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

6. ☐ **Verification of Non-Medical Employment**

   If applicable, this form is to be completed by your previous employer(s). Please have it completed in its entirety. This form should be completed for employment in the past 10 years. This form should be photocopied if you have had more than one employer. Please have it returned directly to this office at the above address by your employer(s). A letterhead or business card must be attached to the form. You may also download the form at www.NJConsumerAffairs.gov.

7. ☐ **Certification of Valid Licensure**

   If applicable, this form is to be forwarded to each state or jurisdiction in which you are licensed. This form may be copied if you are licensed in more than one state or jurisdiction. **Each state or jurisdiction may have a fee for this service. It is the applicant's responsibility to contact each board to find out how much the fee is and where to send it.**

8. ☐ **Certificate of Good Standing Non-Respiratory Care Practitioner License/Registration/Permit/Certificate**

All applicants are required to forward one form to each state where you hold or have held a state-issued license, registration, permit or certificate as a health care provider **other than** a respiratory care practioner. Extra copies may be photocopied if needed.

9. ☐ **Copy of High School Transcript with School Seal/Notarized High School Diploma**

All applicants are required to request that their official high school transcript or its equivalent be forwarded from the high school to this office. **Foreign graduates are required to have their transcripts evaluated by a Board-approved evaluator (the list of evaluators is attached). If your transcripts are not mailed directly from your high school, they must be notarized before sending them to the State Board of Respiratory Care.**

10. ☐ **Notarized Copy of Citizenship/Alien Registration Card/Marriage Certificate**

☐ A. If applicable, applicants who have changed their names must forward a **notarized** copy of the documented proof of their name change to the State Board of Respiratory Care.

☐ B. If applicable, this **notarized** certificate must be provided to prove that you are a legal resident of the United States.

11. ☐ **Notarized Copy of Certificate of Completion (Certificate/Degree)**

All applicants are required to submit a **notarized** copy of the Certificate of Completion **(certificate or degree from an accredited institution or college)** to the Board, proving successful completion of a Respiratory Care program accredited by the Committee on Accreditation for Respiratory Care.

12. ☐ **Certificate and Authorization Form for a Criminal History Background Check**

All applicants are required to submit a **Certification and Authorization Form for a Criminal History Background Check**. Please complete the form in its entirety, sign the form and return it to the above mailing address. If you live out-of-state, fingerprint cards **(if applicable)** with a complete set of instructions will be sent to you upon receipt of the Certification and Authorization Form for a Criminal History Background Check.

Revised October 2013

Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photograph is required with each application.

Do not use staples to attach the photograph.


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Newark, New Jersey 07101
(973) 504-6485


Are you applying for a permanent or a temporary license as a respiratory therapist?

Please put a check in the appropriate box.

☐ Permanent
☐ Temporary

# Application for Licensure as a Respiratory Care Practitioner

Date: _____

A nonrefundable application filing fee of $125 in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

**Please print clearly. You must answer all of the questions on this application.**

## Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ ( _____ )
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

| _____ | _____ | _____ |
|---|---|---|
| Applicant's name (please print) | Applicant's signature | Date |

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

**"Ability to practice respiratory care"** is to be construed to include all of the following:

a. The cognitive capacity to exercise reasonable respiratory care judgments and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of a respiratory care practitioner, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

**"Chemical substance"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

**"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

**"Illegal use of controlled dangerous substance"** means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ _____

Applicant's signature Date

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

   If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
    Last name First name Middle initial

| Type of license or certificate | Number | State or jurisdiction that issued the license or certificate | Date issued/expired |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

11. Have you ever been cited for disciplinary reasons or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

12. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever been named as a defendant in any litigation related to the practice of respiratory care or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of respiratory care or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 11 through 17, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

## Education

1. What is the name and address of the high school you attended?_____
   Name of high school

   _____
   Street address City State ZIP code

2. What years did you attend high school? _____

3. Did you graduate from high school? ☐ Yes ☐ No

   If "Yes," what was the date of your graduation?_____
   Month Year

   If "No," did you study to receive a G.E.D. certificate? ☐ Yes ☐ No

   If "Yes," please provide the name and address of the educational institution that issued your G.E.D. certificate and the date the certificate was issued.

   _____
   Name of educational institution

   _____
   Street address City State ZIP code

   _____
   Date certificate was issued

4. What is the name and address of the colleges or universities you have attended?

   _____
   Name of college or university

   _____
   Street address City State ZIP code

   _____
   Name of college or university

   _____
   Street address City State ZIP code

   _____
   Name of college or university

   _____
   Street address City State ZIP code

   _____
   Name of college or university

   _____
   Street address City State ZIP code

5. List all of the degrees that you have received from recognized colleges or universities. Please have each college or university forward to the Board the official transcript for each degree that you have earned, **after** you have called the Board's staff at (973) 504-6485 to make sure the Board has already received this application and the application filing fee.

| Educational institution | Inclusive years | Degree, Diploma or Certificate | Major | Date granted |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Employment History

1. Please document your work experience below. Begin with your current or most recent experience and then provide the relevant information as you work back in time, chronologically. (You may photocopy this page if you've had more than 3 employers.)

(a) Employer: _____

Address: _____
Street address City State ZIP code

Telephone number: _____
(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

_____

_____

From _____ to _____
Month Year Month Year

Immediate supervisor's name and title: _____

(b) Employer: _____

Address: _____
Street address City State ZIP code

Telephone number: _____
(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

_____

_____

From _____ to _____
Month Year Month Year

Immediate supervisor's name and title: _____

(c) Employer: _____

Address: _____
Street address City State ZIP code

Telephone number: _____
(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

_____

_____

From _____ to _____
Month Year Month Year

Immediate supervisor's name and title: _____

# AFFIDAVIT

**This affidavit is to be executed by the applicant before a notary public:**

State of: _____

County of: _____ } *ss.*

I, _____ , in making this application to the State Board of Respiratory Care for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the State Board of Respiratory Care, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:14E-1 et seq., together with the Rules and Regulations of the State Board of Respiratory Care, N.J.A.C. 13:44F-1.1 et seq., and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

_____
Applicant's signature

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

**Affix Seal Here**

---

**For office use**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# New Jersey Employer's Statement Form

**Section I**: ***If applicable, this section is to be completed by the employee/applicant.*** **Please print clearly.**

I. I ,_____, certify that I have not worked as a respiratory care practitioner
(Applicant/Employee Name)
in New Jersey since May 1992.

**Section II:** ***If the applicant has worked in New Jersey as a respiratory therapist since May 1992, this section is to be completed by the employer.***

II. I, _____, certify that _____ has worked under
(Employer Name) (Employee Name)
my supervision as a/an _____ for _____ in the State of New
( Title of Position) (Hours Per Week)
Jersey. The period worked was from _____ to_____ .
(Start Date) (End Date/Current)

**Check all of the appropriate boxes.**

**Specific Duties Included:**

- ☐ Administration of Medical Gases
- ☐ Application of Oxygen-Administering Apparatus
- ☐ Administration of Environment Control Systems
- ☐ Administration of Humidification and Aerosols
- ☐ Administration of Drugs and Medication
- ☐ Application/Management of Apparatus for Cardio-Respiratory Support & Control

**Initiated Procedures Related To:**

- ☐ Postural Drainage
- ☐ Chest Percussion and Vibration
- ☐ Breathing Exercise(s)
- ☐ Respiratory Rehabilitation

**Assisted With:**

- ☐ Cardio-Pulmonary Resuscitation
- ☐ Maintenance of Natural and Mechanical Airways
- ☐ Insertion and Maintenance of Artificial Airways
- ☐ Measurement of Cardio-Respiratory Volumes, Pressure and Flow
- ☐ Drawing and Analyzing of Samples of Arterial, Capillary and Venous Blood

I certify that the information contained herein is true, correct and complete to the best of my knowledge. I realize that if any of the following is essentially false, I am subject to punishment.

_____ _____
(Name of Facility) (Address of Facility)

_____
(Telephone Number of Facility - Include Area Code)

_____ _____
(Signature of Employee) (Date) (Signature of Employer) (Date)

**RC-4**
**Revised 2009**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# New Jersey Verification of Medical Employment

**(This form is to be completed by the applicant's most recent employer(s).)**

**Employer: Please attach the facility's letterhead and/or business card to this form and send it directly to the Board.**

Applicant's Name: _____

Employer's Name: _____

Employer's Address:_____

Employer's Telephone Number:_____

1. What position did the above individual hold when employed by you? _____

   _____

2. What were his/her dates of employment? From_____ To _____
3. Did he or she leave your employment in good standing? ☐ Yes ☐ No
4. Was this individual on probation, suspended, sanctioned or disciplined while employed by you? ☐ Yes ☐ No
5. Was this individual granted a leave of absence while employed by you? ☐ Yes ☐ No
6. Were any restrictions placed on his or her activities which were not placed on all other employees holding similar positions?

   ☐ Yes ☐ No
7. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No
8. Was he or she ever subject to nonroutine monitoring while in your employ? ☐ Yes ☐ No
9. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No
10. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No
11. Were any malpractice actions filed naming this health practitioner as a defendant that involved his or her period of employment at your facility? ☐ Yes ☐ No
12. Would you consider employing this health practitioner again? ☐ Yes ☐ No
13. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

If you answered "No" to questions number 3, 12 or 13, or "Yes" to questions number 4 through 11, please explain._____

_____

_____

_____

_____

_____

***Please see other side.***

_____

_____

_____

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure. _____

_____

_____

Print the name of the employer supplying information:_____

Signature of the employer supplying information:_____

Date form was completed :_____

**NOTE: COPIES OR FAXES OF THE REQUIRED LETTERHEAD OR BUSINESS CARD WILL NOT BE ACCEPTED AS ORIGINAL DOCUMENTS.**

**PLEASE RETURN DIRECTLY TO:**

**State Board of Respiratory Care**

**124 Halsey Street 6th Floor**

**P.O. Box 45031**

**Newark, New Jersey 07101**

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**Revised 2009**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Out-of-State Verification of Medical Employment

**(This form is to be completed by the applicant's most recent employer(s).)**

**Employer: Please attach the facility's letterhead and/or business card to this form and send it directly to the Board.**

Applicant's Name: _____

Employer's Name: _____

Employer's Address:_____

Employer's Telephone Number:_____

1. What position did the above individual hold when employed by you? _____

   _____

2. What were his/her dates of employment? From_____ To _____
3. Did he or she leave your employment in good standing? ☐ Yes ☐ No
4. Was this individual on probation, suspended, sanctioned or disciplined while employed by you? ☐ Yes ☐ No
5. Was this individual granted a leave of absence while employed by you? ☐ Yes ☐ No
6. Were any restrictions placed on his or her activities which were not placed on all other employees holding similar positions?
   ☐ Yes ☐ No
7. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No
8. Was he or she ever subject to nonroutine monitoring while in your employ? ☐ Yes ☐ No
9. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No
10. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No
11. Were any malpractice actions filed naming this health practitioner as a defendant that involved his or her period of employment at your facility? ☐ Yes ☐ No
12. Would you consider employing this health practitioner again? ☐ Yes ☐ No
13. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

    If you answered "No" to questions number 3, 12 or 13, or "Yes" to questions number 4 through 11, please explain._____

    _____

    _____

    _____

    _____

    _____

***Please see other side.***

_____

_____

_____

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure. _____

_____

_____

Print the name of the employer supplying information:_____

Signature of the employer supplying information:_____

Date form was completed :_____

**NOTE: COPIES OR FAXES OF THE REQUIRED LETTERHEAD OR BUSINESS CARD WILL NOT BE ACCEPTED AS ORIGINAL DOCUMENTS.**

**PLEASE RETURN DIRECTLY TO:**

**State Board of Respiratory Care**

**124 Halsey Street 6th Floor**

**P.O. Box 45031**

**Newark, New Jersey 07101**

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**Revised 2009**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Verification of Non-Medical Employment

**(This form is to be completed by the applicant's most recent employer(s).)**

**Employer: Please attach the facility's letterhead and/or business card to this form and send it directly to the Board.**

Applicant's Name: _____

Employer's Name: _____

Employer's Address:_____

Employer's Telephone Number:_____

1. What position did the above individual hold when employed by you? _____

   _____

2. What were his/her dates of employment? From_____ To _____
3. Did he or she leave your employment in good standing? ☐ Yes ☐ No
4. Was this individual on probation, suspended, sanctioned or disciplined while employed by you? ☐ Yes ☐ No
5. Was this individual granted a leave of absence while employed by you? ☐ Yes ☐ No
6. Were any restrictions placed on his or her activities which were not placed on all other employees holding similar positions?

   ☐ Yes ☐ No
7. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No
8. Was he or she ever subject to nonroutine monitoring while in your employ? ☐ Yes ☐ No
9. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No
10. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No
11. Were any malpractice actions filed naming this health practitioner as a defendant that involved his or her period of employment at your facility? ☐ Yes ☐ No
12. Would you consider employing this health practitioner again? ☐ Yes ☐ No
13. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

    If you answered "No" to questions number 3, 12 or 13, or "Yes" to questions number 4 through 11, please explain._____

    _____

    _____

    _____

    _____

    _____

***Please see other side.***

_____

_____

_____

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure. _____

_____

_____

Print the name of the employer supplying information:_____

Signature of the employer supplying information:_____

Date form was completed :_____

**NOTE: COPIES OR FAXES OF THE REQUIRED LETTERHEAD OR BUSINESS CARD WILL NOT BE ACCEPTED AS ORIGINAL DOCUMENTS.**

**PLEASE RETURN DIRECTLY TO:**

**State Board of Respiratory Care**

**124 Halsey Street 6th Floor**

**P.O. Box 45031**

**Newark, New Jersey 07101**

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**Revised 2009**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Certificate of Good Standing
# Non-Respiratory Care Practitioner
# License/Registration/Permit/Certificate

Please complete the top portion only and forward one form to each state where you hold or have held a state-issued license, registration, permit or certificate as a health care provider other than a respiratory care practioner. Extra copies may be photocopied if needed.

**This section is to be completed by the applicant:**

I,_____, am applying for a New Jersey Respiratory Care Practitioner License.

The New Jersey State Board of Respiratory Care requests that I submit evidence that my License/Registration/Permit/Certificate in the State of _____ is in good standing.

I was granted License/Registration/Permit/Certificate Number_____on _____ .
Date

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **State Board of Respiratory Care, 124 Halsey Street, P.O. Box 45031, Newark, New Jersey 07101**.
Your early attention is appreciated.

_____ _____
Applicant's signature Date

**This section is to be completed by an Official of the Issuing Authority:**

Please complete and return this form to: **Dept. of Law & Public Safety, Division of Consumer Affairs, State Board of Respiratory Care, P.O. Box 45031, Newark, New Jersey 07101**.

Name:_____

License/Registration/Permit/Certificate number:_____
Date issued: _____ Expiration date: _____

Is the License/Registration/Permit/Certificate current? ☐ Yes ☐ No

If "No," please explain: _____

_____

Is the License/Registration/Permit/Certificate in good standing? ☐ Yes ☐ No

If "No," please explain:_____

_____

Additional information or other remarks:_____

_____ _____ _____
Date Print name Signature

_____ _____
State Board Title

**(Seal of the attesting Issuing Authority must be impressed over the signature.)**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Request for Verification of Credentials

**To Applicant:** Complete Section 1 below and submit it, along with the required $5.00 fee for active members and $20.00 fee for inactive members, to:

**National Board for Respiratory Care**
**18000 W. 105th Street**
**Olathe, KS 66061-7543**
**(913) 895-4900**
**www.nbrc.org**

**Section 1:**

☐ I am applying for State licensure in _____, and I am requesting the N.B.R.C. to verify my credential(s) directly to the_____.

☐ I am requesting the N.B.R.C. to verify my credential(s) directly to:

**State Board of Respiratory Care**
**124 Halsey St., P.O. Box 45031**
**Newark, New Jersey 07101**

I hold the following N.B.R.C. credentials:

☐ R.R.T. ☐ C.P.F.T. ☐ C.R.T. - N.P.S.
☐ C.R.T. ☐ R.P.F.T. ☐ R.R.T. - N.P.S.

Print the name under which you were credentialed:

_____
Last First Middle initial Maiden Name

Complete the Information Below:

_____
Social Security Number

_____
Last First Middle initial Former Name

_____
Street Addrees/Apt No. City State ZIP code

_____ _____
Telephone number (include area code) Cell Phone number (include area code)

_____ _____
Signature Date

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**Revised 2009**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# Certification of Valid Licensure

**Please send this form to every board in the state(s) or jurisdiction(s) (except New Jersey) where you are or have been licensed as a Respiratory Care Practitioner.**

**Note to applicant: This form should be forwarded directly to the State Board of Respiratory Care by the out-of-state board(s). Failure to do so may delay the processing of your application.**

**Please complete the top portion only** and forward one form to the board in every state or jurisdiction where you hold or have held a license to practice respiratory care. Extra copies may be photocopied if needed. There may be a charge for this service. Be sure to ask the board(s) where you are licensed about fees for this service.

I,_____, Social Security number _____-____-_____, am applying for a New Jersey Respiratory Care Practitioner's license based on endorsement.

I was granted license number _____ in _____ by the State of _____.
(License Number) (Month / Year)

The New Jersey State Board of Respiratory Care has requested that I submit evidence that my license in the State of _____ is in good standing.
(State where you are licensed)

You are hereby authorized to release any information in my file, favorable or otherwise directly to the New Jersey State Board of Respiratory Care, P.O. Box 45031, Newark, NJ 07101. **Your early attention is appreciated.**

Signature:_____

_____

**This section is to be completed by an official of the board in the state where you are or have been licensed.**

**Please complete and return to:** State Board of Respiratory Care, P.O. Box 45031, Newark, NJ 07101

Name of applicant:_____

License number:_____ Date issued:_____

License issued through (check one): ☐ N.B.R.C. Examination/Credential ☐ State Examination ☐ Reciprocity
☐ Endorsement ☐ Other:_____

Is the license current? ☐ Yes ☐ No If "No," date of expiration:_____

Is the license in good standing? ☐ Yes ☐ No

If "No," please explain: _____

_____

Was the license ever suspended, revoked, or was other disciplinary action taken? ☐ Yes ☐ No

If "Yes," please explain (attach any relevant documents):

_____

_____

Derogatory Information: _____

_____

Remarks:_____

_____

Signature:_____ Date:_____

State Board: _____ Title: _____

**(The seal of the licensing board must be impressed over the board official's signature.)**

**Revised August 2007**

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

# List of Recognized Credential Evaluation Services

**World Education Services, Inc.**
P.O. Box 745
Old Chelsea Station
New York, New York 10113-0745
(212) 966-6311
www.wes.org
9:00 a.m. - 5:00 p.m. - Customer Service
Monday-Friday

**International Education Research Foundation, Inc.**
**Credentials Evaluation Service**
P.O. Box 3665
Culver City, CA 90231-3665
(310) 258-9451
www.ierf.org
8 :0 am.- 4:00 p.m. - Customer Service
Monday - Friday
Info@ierf.org

**International Consultants Inc., of Delaware**
109 Barksdale Professional Center
Newark, DE 19711
(302) 737-8715
www.icdel.com
8:30 am.- 4:00 p.m. - Customer Service
Monday - Friday

**Educational Credential Evaluators, Inc.**
P.O. Box 92970
Milwaukee, Wisconsin 53202-0970
(414) 289-3400
www.ece.org
8:30 a.m. - 4:30 p.m. - Customer Service
Monday - Friday

**Official Use Only**
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

*New Jersey Office of the Attorney General*
Division of Consumer Affairs
State Board of Respiratory Care
P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

**Official Use Only**
☐ Resubmit
_____
Board or Committee
_____

# Certification and Authorization Form For a Criminal History Background Check

**Directions:** Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ ( _____ )
   Last First Middle Maiden Name
2. Address _____
   Street or P.O. Box City State ZIP code
3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year
4. Social Security number _____/_____ / _____
5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $20.25.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.
6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   **Every such conviction on record must be disclosed.** A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   **Note:** Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   **Your continuing responsibility to disclose convictions of crimes or offenses**: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

# Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date